

## **Responding to Questions on Racial and Ethnic Disparities in COVID-19**

The Maine Department of Health and Human Services (DHHS) continues to prioritize understanding and tackling the disparate impact of COVID-19 on racial and ethnic minorities in Maine. This is part of our overarching work toward equity in health and human services across the state's diverse populations. We recently gathered the requests to date from various stakeholders on this topic. In addition to conveying the responses in meetings, we are posting them here so that all may have access to them. Our actions to reduce racial, ethnic, and other disparities in COVID-19 and the health systems is a work in progress. We will continue to provide updates on this work.

**Stakeholder Requests:** In letters, meetings, emails, and other forms of communication, individuals and groups in Maine concerned about the disproportionate impact that COVID-19 has had on racial and ethnic minorities have offered suggestions to DHHS. Below are responses as of the end of June.

### **I. Data Collection and Data Sharing**

#### **(1) Collect data about race/ethnicity for COVID 19 cases.**

The Maine Center for Disease Control and Prevention (CDC) collects race and ethnicity data through testing and the contact tracing process. All demographic data is voluntary. Through June 28, 2020, 12% of all COVID patients have not reported their race and 19% have not reported ethnicity. Those numbers have declined regularly. To help close that gap, DHHS is working with HealthInfoNet (HIN), which supports Maine's health systems, to collect, store and distribute cleansed and secure clinical data. DHHS has worked with HIN to have race/ethnicity added to the portal.

Reported data represent only those individuals with positive test results or who meet a strict definition of probable cases, which likely under-represents the true number of cases in Maine. For individuals not considered to be at high risk, medical providers were advised to diagnose COVID-19 based on symptoms prior to May 18, 2020. Those diagnoses are not included in reported data.

#### **(2) Make public the data for race and ethnicity related to cases, testing, hospitalization, recovery and death.**

As of June 5, 2020, the Maine CDC COVID 19 website now includes a visualization specific to data on race and ethnicity. The data includes cases, hospitalizations, recoveries, and deaths, as well as the state population share for comparison. Data regarding cases is updated daily. Data for hospitalizations, recoveries, and deaths are updated weekly to ensure privacy.

#### **(3) Make reporting of racial and ethnic data mandatory for all hospitals and providers doing testing**

The State does not reject a test because it lacks information on race and ethnicity. DHHS is, however, developing guidance and training for providers that will stress the importance of collecting this data in a culturally and linguistically appropriate manner. The CDC epidemiology

team is trained to ask these questions during contact tracing, including how to talk with patients about why we collect the data.

**(4) Help journalists to accurately interpret data by providing greater narrative**

Maine CDC Director, Dr. Nirav Shah, has and continues to conduct regular press briefings where he provides some context and answers many questions where further clarity is needed. Communications staff from the CDC and DHHS regularly answer questions from journalists seeking to understand the data presented.

**(5) Provide data for Mainers of color living out of state**

When a patient tests positive for COVID 19, their case is counted in the data for their state of primary residence, regardless of where they receive the test or treatment. Therefore, these Mainers of color who live out of state are already included in our data.

**(6) Disaggregate data to further understand who is represented in each racial category**

DHHS has explored the possibility of further disaggregation and sought examples of best practice from other states via the COVID 19 Tracking Project but found no such examples. The Department will continue to follow federal CDC recommendations for the race and ethnicity categories because it allows us to benchmark against other states and is consistent with the way data are collected across the Department. That said, DHHS is currently looking into creating a survey for COVID 19 patients and, if implemented, would include additional granularity on race and ethnicity.

Additionally, we have been collecting data through contact tracing on language. Of the 1,284 enrollees as of June 26, 198, or 15%, reported a primary language other than English. Note that not all contacts develop COVID-19.

| Language     | Number     | Percent    |
|--------------|------------|------------|
| French       | 75         | 6%         |
| Somali       | 61         | 5%         |
| Lingala      | 12         | 1%         |
| Spanish      | 12         | 1%         |
| Kinyarwanda  | 9          | 0.7%       |
| Portuguese   | 9          | 0.7%       |
| Arabic       | 8          | 0.6%       |
| Other*       | 12         | 1%         |
| <b>TOTAL</b> | <b>198</b> | <b>15%</b> |

\*Other languages reported include Kirundi (3), Cambodian (2), Nyer/Nuer (2), Amharic/Oromi (1), Burundi (1), Dari (1), Maay Maay (1), and Zande (1).

**(7) Maintain the privacy of individuals**

DHHS is required by law to maintain the privacy of individuals. We strive to be transparent and provide communities with the information they need to remain safe and healthy, but we must

balance that with the legal obligation to maintain privacy. When numbers are small, the potential for identification of individuals increases and thus, in these cases, we suppress the information. Small numbers and privacy rules make it challenging to further disaggregate data or provide county by county breakdown of race and ethnicity.

## **II. Education and Prevention**

### **(1) Engage community health workers**

The State is contracting with 10 Community Action Program (CAP) agencies across the state to assist with the provision of temporary social services required for COVID positive patients or close contacts to successfully isolate or quarantine. In May 2020, Sharon McDonnell MD MPH joined DHHS to help coordinate those efforts across the state. She has extensive experience leading social supports and contact tracing for infectious disease outbreaks around the world. In addition, the State is contracting with Wabanaki Public Health and Catholic Charities of Maine to help ensure culturally appropriate services, including translation, interpretation and cultural brokering. DHHS issued those contracts the week of June 2. Catholic Charities will sub-contract with community-based organizations to provide culturally appropriate assistance with Case Investigation, Contact Tracing and Case Enrollment. As part of that arrangement, Catholic Charities will work with several agencies that utilize community health workers in Portland and Lewiston.

### **(2) Translation of key materials**

Since the inception of the pandemic, the Maine CDC and DHHS have provided translation of key documents in multiple languages. This includes information on testing, contact tracing, COVID-19 Prevention Checklists, and Executive Orders. We are open to feedback from stakeholders about what additional material would be helpful.

### **(3) Prioritize distribution of PPE to minority communities**

The supply of personal protective equipment (PPE) has been a challenge across the nation. The CDC, in collaboration with the Maine Emergency Management Agency (MEMA), has distributed 1.5 million items of PPE to organizations requesting it through the County Emergency Management Agencies. Priorities have been adjusted based on need, including to congregate living residents and staff. As supply chains increase, we have sent cloth face coverings to CDC District Liaisons to distribute to community organizations. Approximately 7,200 face cloth coverings have been distributed to community-based organizations via CDC District Liaisons.

### **(4) Educate about available supports and process of contact tracing so that people understand that it is worthwhile and beneficial to get tested and, if positive, isolate.**

As part of its contract requirements, Catholic Charities will subcontract with ethnically led or operated community-based organizations (ECBOs) that will prioritize an education awareness campaign about the importance of testing and available supports, including isolation support in local hotels, food, child care, etc.

The CDC has produced additional materials that explain the contact tracing process. They are now available in several languages. Additionally, the Office of Child and Family Services (OCFS)

has produced guidance in several languages for [how to prepare if a parent becomes too ill to care for their child](#). The Office of MaineCare Services has guidance in several languages regarding accessing coverage for testing and treatment of COVID-19.

- (5) Strengthen regulations for growers to ensure safety of migrant workers. How can we work together to figure out the best protocols for farmworkers coming from other states? How can we make sure that workers know their rights in terms of being tested or not being tested?**

Maine DOL has issued [guidance](#) for agricultural employers. In addition, the CDC worked with Maine Mobile Health to produce a [guidance](#) document for growers and has been working with local resources to ensure that both growers and farmers are aware of supports and guidelines.

### **III. Testing**

- (1) Ensure access to testing regardless of insurance coverage and immigration status**

[Guidance](#) on MaineCare explains coverage of testing and diagnosis of COVID-19 for people who do not have other health insurance, regardless of immigration status.

- (2) Provide testing for all people of color, those working in congregate settings, i.e., nursing and group home staff, farmworkers, grocery workers, medical staff, and those living in high density public housing or close quarters.**

The current [Standing Order](#) issued by DHHS allows anyone at elevated risk of exposure to COVID-19, regardless of whether they have symptoms, to be tested without the need for an order from their health care provider. As explained in answers to [frequently asked questions](#), the Standing Order covers people of color who live in communities where there are high rates of infection and/or who work in settings where there is elevated risk of exposure, including, but not limited to, “seasonal and migrant agricultural workers, employees of lodging facilities and congregate living settings, and employees of businesses who have direct, daily contact with members of the public.”

In addition, the State supports COVID-19 testing of individuals living in public housing units. The samples collected will be sent to the Maine Health and Environmental Testing Lab. The housing facilities and/or the municipality will need to identify options for swabbing/specimen collection. The City of Portland, for example, is working with Portland Minority Health to coordinate testing for individuals living in public housing units in Portland.

Similarly, we are working with Lewiston health care providers and Community Health Workers to encourage people in public housing and New Mainer families to get tested. The logistics are still being worked out, as we must be mindful not to create a new hotspot by sending large numbers of people to medical facilities at the same time. We do not have the ability to bring testing to all housing sites, but we continue to build capacity and support conveniently located collection sites, referred to as “swab and send sites,” across the state. To increase flexibility, the request for applications (RFA) for swab and send collection sites encourages mobile units. Such sites will begin operation in July.

- (3) Culturally appropriate services at test collection sites that clearly explain next steps**

The social support services funded by DHHS include education and outreach regarding COVID-19 testing processes, quarantine and isolation. Community-based organizations, including ethnic community based-organizations, are working on culturally appropriate services and educational materials that will be available at these sites. In some cases, cultural brokers may also be present at testing collection sites.

**(4) Conveniently located test collection sites**

In addition to current providers, the State has issued a request for applications (RFA) for swab and send test collection sites. Potential sites were suggested based on several factors that include the population and infection rate in certain communities.

**(5) Many immigrants don't have a primary care doctor because they don't have health coverage. What can we do to make sure they know where they can go and get access to a test if they do go?**

Sharon McDonnell MD, MPH is working with Wabanaki Public Health, Catholic Charities, and CAP agencies, as well as CDC District Liaisons to ensure that individuals are aware of the local test collection sites and the availability of getting tested under the Standing Order. The Standing Order provides the authority for testing of individuals at elevated risk of exposure to COVID-19, even if an individual doesn't have a primary care doctor. In addition, DHHS has moved forward to make Emergency MaineCare available for eligible individuals, regardless of immigration status. [The Office of MaineCare Services issued guidance in May regarding the coverage of uninsured individuals for testing.](#)

**(6) How will the State ensure that symptomatic people in our communities get tested? We know that there are people in close contact with those individuals who are also not getting tested.**

Despite increased testing capacity, we understand that there are several barriers to testing, including stigma, fear, and misunderstanding. The State is utilizing social support services and cultural brokering contracts mentioned above to leverage community organizations, which have built trust within their communities, to increase education around the importance of testing, access to testing, and availability of isolation support resources. This education underscores the importance of contact tracing and how it works. Once contacts are identified through contact tracing, CDC staff will engage community health workers or cultural brokers as appropriate to encourage testing and stress the need for quarantine. In addition, DHHS has issued a Standing Order, which allows individuals at elevated risk of COVID-19 to be tested, regardless of whether they have symptoms.

As part of our education for providers, we are emphasizing the importance of clearly explaining contact tracing and encouraging testing for close contacts. In addition, several providers have advertised the availability of testing (i.e., Central Maine Health Care).

**IV. Contact Tracing**

**(1) Diversity of staff**

As we increase hiring for COVID-19 response, we have circulated job announcements to numerous stakeholders in hope of hiring people with lived and learned experience in connection with people of color. In addition, we have included in the job descriptions qualifications that

encourage diversity, including experience communicating with individuals from different cultural backgrounds and preference for multilingual applicants.

Through its strategic planning process on diversity, equity and inclusion, the Department will continue to develop best practices for hiring for diversity.

**(2) Use of cultural brokers or community health workers to ensure understanding and participation.**

Catholic Charities of Maine is subcontracting with community-based organizations to provide assistance to contact tracers where that need is identified. One indicator of need is limited English proficiency, although other types of cultural brokering will be offered as well.

**(3) More education about contact tracing - what it is and how it works.**

In response to this request, the CDC has produced additional materials about contact tracing, available now on the website in several languages. The CDC Epidemiology team has attended several local meetings with district liaisons to discuss what contact tracing is and how it works.

**(4) Can we connect with epidemiologists to better understand this process and make sure it is appropriate for our communities?**

Many of our meetings have included epidemiologists. We will continue to work to make them accessible.

**V. Social Service/Isolation support**

**(1) Culturally and linguistically appropriate services**

The State has directed funds to Community Action Program agencies, Catholic Charities of Maine, and Wabanaki Public Health for services. They will subcontract with local ethnic, community-based organizations to ensure culturally and linguistically appropriate services can be provided.

**(2) Isolation support for families that cannot properly isolate at home**

**i. Lewiston hotel**

MaineHousing has secured a hotel in Lewiston that will accept COVID positive patients and family members who need assistance to remain in isolation or quarantine due to close living quarters. Arrangements for hotel rooms are made through the contact tracing process and referred to Community Concepts or Catholic Charities of Maine.

**ii. Portland hotel**

MaineHousing has secured a hotel in Portland that will accept COVID positive patients and family members that need assistance to remain in isolation or quarantine due to close living quarters. Arrangements for hotel rooms are made through the contact tracing process and referred to Preble Street.

**iii. Bangor hotel**

MaineHousing has secured a hotel in Bangor that will accept COVID positive patients and family members who need assistance to remain in isolation or quarantine due

to close living quarters. Arrangements for hotel rooms are made through the contact tracing process and referred to Penobscot Community Health Care.

**iv. Hotels in rural areas for migrant farmworkers that need to isolate**

MaineHousing is currently exploring options for hotels in more rural areas that are willing to house COVID positive patients or close contacts, including migrant farmworkers if they are unable to safely isolate in their existing housing.

**(3) Encourage testing for children of COVID positive cases**

Through the contact tracing system, members of the Epidemiology team encourage families of a positive patient to quarantine and monitor for symptoms. CDC guidance does not require asymptomatic children to be tested.

We heard from many in the community that there is significant fear that testing children could lead to child welfare involvement. OCFS worked with Wabanaki Public Health and the Immigrant Resource Center of Maine to create guidance for families on how to plan in the event a [caregiver is too ill to care for the child](#). That guidance has been translated into several languages.

**(4) Help workers communicate with employers by providing a letter confirming the release from quarantine or isolation.**

Such a letter is available upon request from the CDC Epidemiology team.

**VI. Address pre-existing gaps**

**(1) Address gaps in coverage for immigrants that create more medical vulnerability**

**(2) Recreate the Office of Minority Health within the CDC**

The Department's mission is to promote health, safety, resilience, and opportunity for all people in Maine. This requires changes in workforce, policy, and engagement to eliminate the unacceptable disparities associated with race and ethnicity. DHHS created a new position within the Commissioner's Office focused on these needs and in November 2019 hired Leana Amaez as the manager for diversity, equity, and inclusion. The Department then launched a strategic planning process early in 2020 to advance diversity, equity, and inclusion. This plan will examine both policy as well as organizational changes that may be needed such as recreating the Office of Minority Health. Stakeholders will be consulted as part of this process.

**VII. Accountability**

**(1) Accounting for funds and how much has gone to organizations serving racial and ethnic minorities.**

In several cases, federal funding has bypassed the state government and been allocated directly to health centers or other providers. In other cases, providers who serve various racial and ethnic populations may not be readily identifiable among other providers of similar services. We will continue to explore whether it is possible to provide this information as requested.

**(2) Demographics of staff dedicated to COVID-19**

The Department has since 2019 [posted](#) the demographics of its workforce. Many people across the Department are working most, if not all, of the time on COVID-19. We will release information about new hires related to COVID-19 once that process is complete.